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OUTPATIENT LETTER STANDARDS IMPLEMENTATION GUIDANCE

JULY 2017

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The Professional Record Standards Body

The independent Professional Record Standards Body (PRSB) was registered as a Community Interest Company in May 2013 to oversee the further development and sustainability of professional record standards. Its stated purpose in its Articles of Association is: “to ensure that the requirements of those who provide and receive care can be fully expressed in the structure and content of health and social care records”. Establishment of the PRSB was recommended in a Department of Health Information Directorate working group report in 2012.

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Professional Record Standards Body

32-36 Loman Street,

London, SE1 0EH.

www.theprsb.org

support@theprsb.org

Community Interest Company No 8540834

1 Purpose of this document

- 1.1 The purpose of this document is to provide guidance for the implementation of the clinical record headings in electronic outpatient letters sent from outpatient clinics to registered GPs, and copied to patients and their carers, following an outpatient attendance. An outpatient letter may be given different names in different places but it is the communication from a clinician (doctor, nurse or allied health professional) or a multi-disciplinary team following a consultation which may be face to face in a clinic setting either in a hospital or community location or via electronic means, such as telephone or online.
- 1.2 This document provides:
 - a) Guidance to implementers and suppliers on how to implement the PRSB/Academy of Medical Royal Colleges (Academy) outpatient headings including the structured and coded data. It is intended to complement NHS Digital developed technical specifications to be published and provide complementary guidance to implementers (NHS organisations and GP practices) and IT system suppliers on how to implement the messages.
 - b) Good practice guidance to clinicians relating to recording and receipt of information in the outpatient letter.
- 1.3 The document does not specify:
 - a) Requirements for the way in which sending or receiving systems should operate as this will depend on functions and user interfaces of existing systems.
 - b) The circumstances where an outpatient letter should to be sent. That is a local decision.

2 Background

- 2.1 The National Information Board published its framework for action in November 2014 which states:

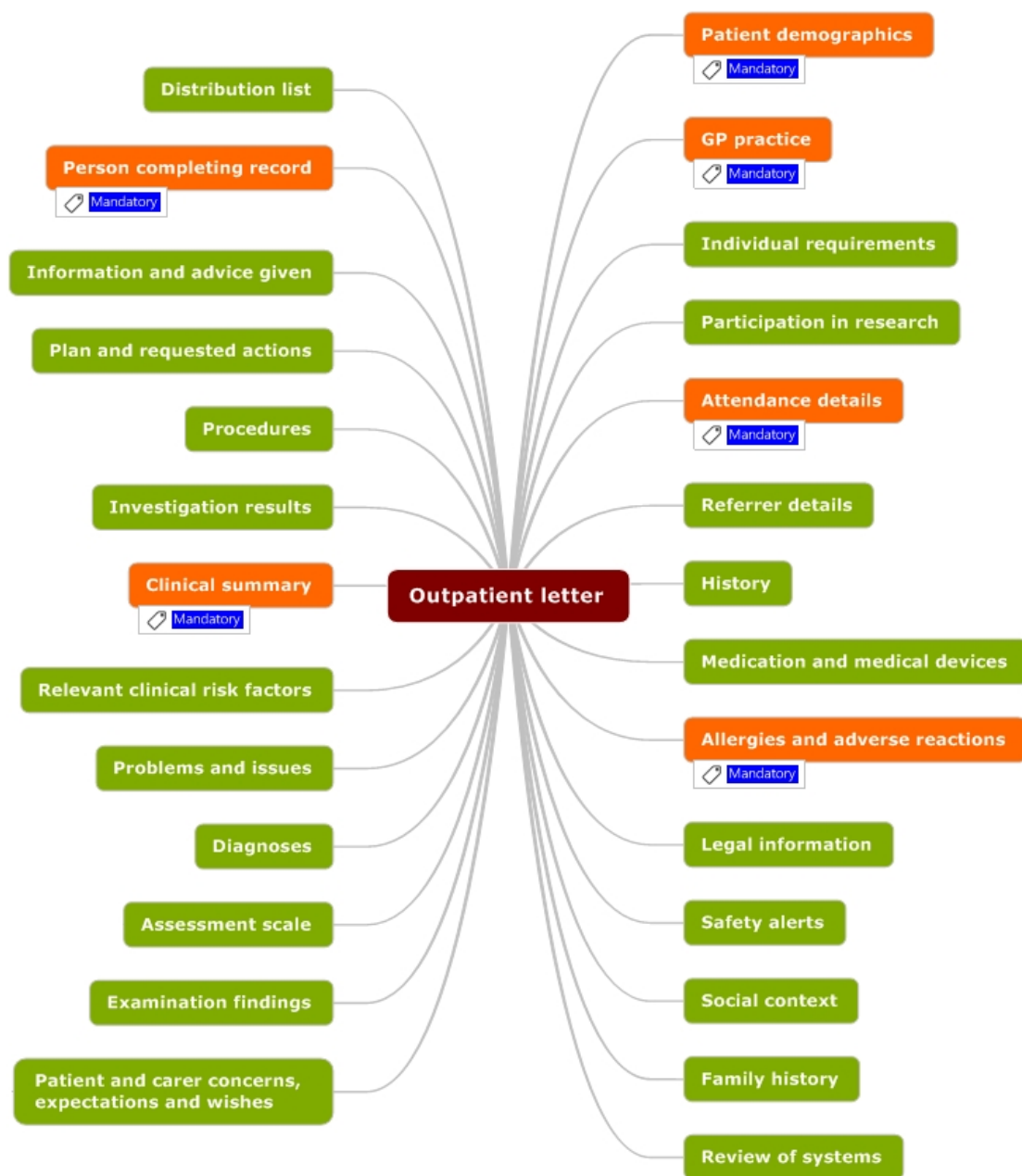
'We propose the adoption of the Academy of Medical Royal Colleges' publication Standards for the clinical structure and content of patient records with a requirement that all organisations and clinical systems should implement the standards, following consultation and completion of an impact assessment.'

- 2.2 The Academy standards for the clinical structure and content of patient records were published in 2013. The scope included headings for admission, discharge, handover, referral and outpatient letters. The standard headings are common across all use cases to enable re-use (so that for example, the medication information recorded in a GP referral can be used by the hospital in medicines reconciliation during admission and to identify changes in medications for inclusion in the outpatient letter). The PRSB/Academy 2013 record headings form the structure for outpatient letter, where minor amendments have been made (eg to reflect changes in legislation and good practice) these are identified in an Appendix.
- 2.3 The standards have been endorsed as fit for purpose by 50 organisations that give professional leadership to the medical, nursing and clinical professions, including the Academy. The standards were adopted by the Professional Records Standards Body (PRSB). The PRSB is a Community Interest Company owned by UK health and social care professional bodies and patient organisations.
- 2.4 The Transfer of Care (ToC) initiative within NHSD has been established with the primary purpose of driving the establishment and uptake of consistent professional and technical data standards across the health and care sector, with particular focus on the documents that support the transfer of care between organisations and care providers. The Transfer of Care Initiative is part of programme 13: Integration projects, which sits under the National Information Board domain D.
- 2.5 To support care integration, as signaled in the published 2016/17 NHS Standard Contract, requirements have been tightened for the production and transmission to GPs of letters (where clinically required) following outpatient clinic attendance. The current timescale for production (within 14 days of attendance) will reduce progressively to 10 days (from 1 April 2017) and 7 days (from 1 April 2018).
- 2.6 The PRSB was commissioned by NHS Digital in November 2016 to undertake a project to develop and assure information models to enable key structured and coded clinical data to be transferred in a computable form in outpatient letters. A message specification based on these models will be published by the NHS Digital in quarter 2, 2017-2018. The deadline for transfer of outpatient letters as a structured message capable of carrying both human readable narrative and coded (SNOMED CT) information, using or consistent with the Academy of Medical Royal College headings is 1 October 2018. MESH or TMS services will provide the transport mechanism.

- 2.7 There is a programme to implement SNOMED CT on GP systems by June 2017. There is an [SCCI Information Standards Notice \(SCCI0052\) for the NHS dictionary of medicines and devices \(dm+d\)](#) requiring that electronic systems that exchange or share information about medicines relating directly to a patient's care must adhere to the standard by using dm+d identifiers and descriptions when transferring information by June 2017.

3 The outpatient letter content

- 3.1 The content of the outpatient letter is aligned based in the PRSB/Academy clinical record standards 2013. To provide the context for this implementation guidance, the set of headings included in the outpatient letter is provided on the diagram below. Detailed information models are available via the NHS Digital website.
- 3.2 ***The order in which headings appear in the outpatient letters can be agreed locally.***



4 Benefits of implementing interoperable outpatient letters

4.1 Potential benefits from having interoperable electronic outpatient letters, which reflect the requirements of patients, carers, people being supported in care services and care professionals, are significant. They include:

4.1.1 *Improved patient safety by:*

- having information which is needed for safe continuity of care to be available on a timely basis.

- avoiding transcription errors when medication information is electronically transferred to the GP record (following clinician review), without the need for re-entry.
- 4.1.2 *Improvements to patient care and patient satisfaction by:*
- having consistent and timely information (including medications, diagnoses, procedures and allergies) transferred to all relevant care professionals and their GP practice.
 - providing patients with legible up to date information about their outpatient attendance.
- 4.1.3 *Support for new more integrated and person-centred ways of working, including:*
- people being able to access to their records on line.
 - increased efficiency for multidisciplinary teams by providing structured and coded information on diagnoses, procedures and medications which can be reused for new ways of working as teams develop and expand.
- 4.1.4 *Time savings for NHS organisations by:*
- removing the need to develop and design content locally, by using national standards
 - reducing the duplication of recording.
- 4.1.5 *Information being readily available for use in improving quality of care through:*
- re-use in clinical audit and research.
 - increased ability to measure and improve actual patient clinical outcomes rather than process outcomes.
- 4.1.6 A hugely increased opportunity for future development of patient led care by ensuring interoperability between multiple systems, including personal health records.
- 4.1.7 Sites implementing standard electronic outpatient letters will have access to learning from other sites that have done this previously, to support them to implement more effectively.
- 4.2 In summary, there are major benefits from producing an information model which reflects patient and care professional requirements, and is underpinned by good clinical practice. These include enabling the electronic communications, which are based on the model, to be implementable in the NHS in a way which assures the delivery of the benefits set out above.

5 General guidance

- 5.1 The scope of the Outpatient letter communication is the outpatient letter sent, following an outpatient encounter, by the outpatient clinic to the GP and copied to patients and carers. Although copies of the communication may be sent by the outpatient clinic to others, eg other health and social care providers, this would be by local agreement. The communication will cover:
- Letters produced by a consultant's team, nurses, nurse practitioners and Allied Health Practitioners (AHPs) following an outpatient episode and communicated to GP practices and patients.
 - Letters produced from multi-disciplinary team outpatient consultations.
 - Letters produced following outpatient consultations that occur face-to-face, by telephone or by video conferencing.
 - Letters produced during initial and follow-up outpatient consultations.
- 5.2 It is acknowledged that outpatient letters are increasingly written to patients and copied to GPs. In these cases the letter can act as an agreement between the patient and their healthcare professional. It is expected that this guidance will be applicable to these letters also, in that the same headings will be appropriate.
- 5.3 Some outpatient clinics will send a letter when a patient does not attend an outpatient attendance. These letters are not within scope of this guidance. However, where 'Did not attend' letters are sent, the letter would contain data to be locally determined, but compliant with existing headings.
- 5.4 It is not expected that all headings will be used in every outpatient letter. The headings used will depend on the type of encounter (initial or follow-up), consultation method (telephone, face-to-face), specialty and discipline. Local decisions should be made about which headings are appropriate, and these may vary between specialty, service and discipline.
- 5.5 There should be a single outpatient letter, containing all pertinent information, sent out on a timely basis in-line with NHS contract stipulations.
- 5.6 The recipient of the outpatient letter should be able to read all the content of the outpatient letter (ie any coded data should be carried with the associated text).
- 5.7 Patients (or their designated carer or guardian where applicable) should get a copy of the outpatient letter and so it should be written in a way that is understandable to the general public. This may be difficult where technical information needs to be communicated, and in such circumstances, providing explanatory information in easy to read leaflets to patients should be

considered. Providing the documentation in alternative formats and face to face communication should also be considered to meet individual requirements (see **the NHS accessible information standard.**)

- 5.8 The outpatient letter should be brief, containing only pertinent information on the outpatient attendance, rather than duplicating information which GPs already have access to in their own records.
- 5.9 The outpatient letters may have contributions from multi-disciplinary team members, not just an individual clinician. The local hospital system should retain an audit trail of the provenance of all contributions. Outpatient letter authors, including allied health professionals, will need to be using integrated digital care records to ensure that outpatient letters to GPs contain their contributions.
- 5.10 The outpatient letter is designed to be auto-populated as far as possible from Trust Electronic Patient Records (EPRs), with the expectation that, in time, auto-population will include supply of appropriate SNOMED CT codes.
- 5.11 Local implementation of the outpatient letter should involve patients and carers throughout to ensure that the content is expressed in a way which is person-centred and that support is provided to help patients and carer to understand the contents.
- 5.12 A trading agreement will need to be drawn up between the hospital and participating practices, including:
 - Details of the information to be communicated, including which optional sections will be utilised.
 - The sequence of the sections.
 - Which fields will be coded and which textual.
 - Mapping from local headings/fields to those in the outpatient letter message. The mapping should be owned by a clinician in each organization.
 - Requirements for receipt of the outpatient letter, e.g. use of a secure generic mailbox.
 - New work processes for producing and receiving the electronic outpatient letters.
 - Where there is no information recorded in a section in the outpatient letter, that section should be excluded from the outpatient letter message, to avoid the recipient receiving a communication with blank sections.

6 Mandatory and Optional

This section identifies what is mandatory and what is optional in an outpatient letter from both a technical and a good clinical practice perspective.

a. Technical requirements

- 6.1.1 All outpatient letter sections must be supported by IT systems, but they may not all be included in every local implementation. This means that all the sections should be available for local organisations to use, but there should be flexibility to allow local choice about which headings to use.
- 6.1.2 A small number of the sections are MANDATORY and this means that they must be included in all outpatient letters sent by the sending organisation. Other sections are optional. Where there is no information recorded in an optional section in the outpatient letter, that section should be excluded from the outpatient letter message, to avoid the recipient receiving a communication with blank sections.
- 6.1.3 To aid clinicians using electronic systems to create outpatient letters, it is recommended that:
- Data is pre-populated where it is appropriate.
 - User interfaces do not restrict the order in which clinicians enter data to be included in the outpatient letter, so that clinicians can navigate forwards and backwards to complete or partially-complete sections as information becomes available. This does not negate the rule under 6.1.2 which stipulates that a letter cannot be *sent* unless all MANDATORY sections are completed.
- 6.1.4 The MANDATORY headings are:

Mandatory
Patient demographics
GP practice
Attendance details
Allergies and adverse reactions

Clinical summary
Person completing the record

6.1.5 Within the above sections, some of the record entries and fields within them will be mandatory, but others will be optional. The information models define which are mandatory and which are optional.

b. Good practice requirements

6.2.1 A distinction has been made between sections which are REQUIRED or OPTIONAL. The definition of each is given below

:

- a) REQUIRED: if there is information recorded it should be sent to the recipient.
- b) OPTIONAL: a local decision as to whether information is sent to the recipient.

6.2.2 The required and optional headings are listed on the table below:

Required	Optional
History	Social context
Plan and requested actions	Assessment scales
Diagnoses	Clinical review of systems
Information and advice given	Clinical risk factors
Legal information	Distribution list
Procedures	Examination findings
Medications and medical devices	Family history
Safety alerts	Investigation results
Individual requirements	Participation in research
Problems and issues	Patient and carer wishes
Referrer details	

6.2.3 If a section is marked as MANDATORY or REQUIRED it should not be 'downgraded' to OPTIONAL by local agreement. However, it can by local

agreement be upgraded from OPTIONAL to either REQUIRED or MANDATORY.

- 6.2.4 Good practice would dictate that some data items should be REQUIRED for a letter following a patient's first outpatient encounter and OPTIONAL for a letter following a follow-up outpatient encounter. Likewise, good practice would dictate that some data items should be REQUIRED for a letter following a follow-up outpatient encounter, but OPTIONAL for a letter following an initial outpatient encounter. Where this situation occurs the information model shows the data items as OPTIONAL. Additional guidance is provided for specific data items, where appropriate, in the part of this document called '*Guidance on specific sections*'.
- 6.2.5 Clinicians should always use professional judgement to determine what information should be communicated in an outpatient letter. Just because the system records information about the consultation does not mean that it would be relevant to send it to the GP.

7 Explanation of terms used in information models

7.1 This section provides explanation of terms used in the clinical information models.

Term	Definition
Cardinality	The number of elements in a set. E.g. The medications and medical devices section may have 0 to many medication records in it.
Section or Container	This is the equivalent of a main heading in the PRSB/Academy headings, eg allergies and adverse reactions, procedures, etc.
Record entry	A single record, eg a medication item or a diagnosis, which will be made up of one or more elements (ie sub-headings, where data structures have not yet been defined) or data items, eg name, form route, dose amount of medication.
Cluster	A group of data items which make up a record entry, for example, diagnosis record entry is made up of the following data items: diagnosis/symptom, stage of disease and comment.
Iteration	A rule which applies to each repetition of a record entry, for example, only one medication item can be included in a medication record entry.

8 Coding

- 8.1 The *Personalised Health and Care 2020 framework for action* recommends the use of SNOMED CT and the dictionary of medicines and devices (dm+d). Local decisions need to be made about when these codes are to be carried in outpatient letters, depending on local system capabilities and plans.
- 8.2 Please note:
- The receiving GP systems are due to have been migrated to SNOMED CT by April 2018.
 - In future years the ambition is for SNOMED CT and dm+d to be the only clinical coding schemes in use in the NHS by 2020.

9 Guidance on specific sections

a. Patient demographics

- 9.1.1 A patient's email address should be included if the patient is receiving the letter via emails.

b. GP practice

- 9.2.1 If a patient is not registered with a GP practice, then the GP practice record entry should appear in the outpatient letter with the text "No known GP practice".
- 9.2.2 Normally patients are registered with one GP practice. Outpatient letters will go to the GP surgery that the patient is permanently registered with.
- 9.2.3 An outpatient letter can be sent to more than one GP practice, where a patient has a registered practice but is treated as a temporary registration (e.g. whilst on holiday) by another practice. The registered GP practice can be obtained from the PDS. Suppliers should enable more than one GP practice to be recorded to accommodate temporary registration.

c. Referrer details

- 9.3.1 'Referrer details' MUST be completed for an initial appointment outpatient letter. It is optional for follow-up appointments.

d. Attendance details

- 9.4.1 One of "Specialty" or "Service" MUST be completed.

e. Diagnoses

- 9.5.1 The outpatient letter should inform the GP of the main diagnosis or disorder, or diagnoses or disorders that were important during the attendance including

any new diagnosis that came to light during the attendance. In the absence of a diagnosis or disorder symptom or symptoms should be communicated.

- 9.5.2 When a diagnosis has not yet been made, the most granular clinical concept with the highest level of certainty should be recorded. This may be a symptom or sign that may evolve over time, as a conventional diagnosis is reached. For example, 'dyspepsia' may be the diagnosis when a patient first presents with indigestion, upgraded to 'gastric ulcer' when this is found at endoscopy, and 'gastric cancer' when biopsies reveal this.).
- 9.5.3 Unconfirmed or excluded diagnoses should not be recorded in structured coded fields, but may be listed in free text in the comments field. Thus, in the example above, gastric ulcer and gastric cancer may be in a list of differential diagnoses at presentation, but the symptom, dyspepsia, should be recorded in the diagnosis field. The differential diagnoses should only be recorded in free text in the comments field, and not in a coded diagnosis field until confirmed with confidence.
- 9.5.4 Historical inactive diagnoses, where they are clinically important, should be carried in the clinical summary as narrative to provide some explanation, for example - prior history of breast cancer but no evidence of any recurrence on CT carried out during this admission.
- The same guidance applies to the recording of 'co-morbidities', which should be recorded as separate diagnoses.
- 9.5.5 In some situations a diagnosis may need to be qualified by a number of attributes to give further detail. A generic approach to these attributes (such as grade; severity; distribution; behaviour; laterality etc) has not yet been agreed. Until this is achieved it is recommended that these features are recorded as free text comments.
- 9.5.6 Diagnoses, disorders and symptoms may also be 'problems' or 'issues', depending on the context in which they are recorded.
- 9.5.7 Dietetics: The nutritional and dietetic diagnosis (or impression as some refer to it), would sit best within the problems and issues element rather than the medical diagnosis element. The nutrition and dietetic diagnosis is the key aspect of a patient's health and wellbeing that the Dietitian can make a difference (aside from the rest of the MDT) and is different to the medical diagnosis. The plan and interventions that a Dietitian goes on to make with the patient are aimed at treating the nutrition and dietetic diagnosis.

Some departments use the term 'nutrition impression' or 'dietetic impression' rather than 'nutrition and dietetic diagnosis' because using the term diagnosis can cause confusion with the medical diagnosis for some.

f. Problems and issues

- 9.6.1 The outpatient letter should inform the GP of the main problems or issues or that were important during the attendance. This is a summary of problems that require investigation or treatment. This would include significant examination findings, symptoms and signs, which are likely to have relevance and are not a diagnosis.
- 9.6.2 Formulation in mental health is *not* communicated under this heading. Formulation is communicated under clinical summary.

g. Procedures

- 9.7.1 All procedures undertaken SHOULD be included in the outpatient letter, including *diagnostic* as well as *therapeutic* procedures (including medications administered DURING the attendance).
- 9.7.2 The “*Procedures*” heading may be displayed as treatments and interventions in the local record for recording this information if this is preferred term but it should be mapped to procedures for the purpose of communicating this information through the outpatient letter as the underlying information model would be the same.
- 9.7.2 Outcomes or results of procedures should be recorded in the ‘comments’ field.
- 9.7.3 The outpatient letter should include the operation, treatment or therapeutic intervention which was actually carried out, not the planned procedure, as this may have been changed. The detail should be taken from the record of the actual procedure (e.g. operating note) rather than the planned procedure (e.g. consent to treatment).
- 9.7.4 All those procedures deemed to be clinically important for future care should be listed. Thus venesection would not usually merit noting, unless undertaken as a therapeutic procedure for polycythaemia.
- 9.7.5 Whilst hospitals use OPCS codes for procedures, these cannot be used by GP practices, so should not be included in outpatient letters.
- 9.7.6 Adverse reactions to anaesthesia should be recorded in the allergies and adverse reactions section, rather than the procedures section, but should be displayed in both the allergies and adverse reactions section and the procedures section, under the specific anaesthesia issues heading. The

anaesthesia issues recorded in this section could include for example, “short neck, difficult to intubate” and the actual intubation grade.

h. Medications and medical devices

i. Preparing the Medications and medical devices summary at the sending end

9.8.1.1 It is very important that a full and accurate summary record of medications is contained within the outpatient letter. This should include:

- a) Any changes made to medication that was current at the time of attendance – such as changes of dosage
- b) Any medications that were current at the time of attendance which were discontinued either during the attendance
- c) Any new medications added during the attendance and which should be continued following the attendance

The reasons for any of the above (i.e. changes, discontinuations or additions of medication)

9.8.1.2 The following should NOT be included under the “Medications and Medical Devices” heading.

- a) Medication administered during the attendance. This should be included under the “Procedures” heading.
- b) Any medications that were current at the time of attendance and which the clinic wants the patient to continue following the attendance.

9.8.1.3 Ideally the above information should be generated semi-automatically from a hospital e-prescribing system such that drug names will be automatically represented by dm+d codes and also as far as possible the appropriate fields for route, dosage amount and dosage timing etc. will be completed. It is however recognised that, at least initially, much of this information will need to be entered manually. Please see section below (9.8.4) which outlines the differences between dose based and product based prescribing and which provides guidance as to how the various fields available should be used in each case.

9.8.1.4 Whilst medical devices that are prescribable in primary care are generally well represented in dm+d, there are other kinds of devices used in hospital care. While these may well be codified in SNOMED CT or in some other proprietary coding scheme they will generally not be prescribable in primary care. The following rules apply ONLY for a hospital system which uses dm+d. When entering information about medications and devices into the outpatient letter the following rules should be applied:

- a) Any medication item or medical device that can be dm+d coded should be entered as a 'medication item' entry. Changes and reasons for change can be also handled here.
- b) Where any medication has been discontinued this should be entered using the 'medication discontinued' entry
- c) Where a medical device has no dm+d code then this should be represented as text using the 'medical devices' record entry.

9.8.1.5 Where recording dose duration directions, the following examples are provided to clarify definitions for two of the coded text items which appear similar. In both cases, these directions are not an absolute instruction. They are:

- a) 'continue medication indefinitely' - ongoing treatment planned for example when starting daily aspirin or a statin. There will be circumstances where you would stop them such as a GI bleed.
- b) 'do not discontinue' refers to medication where suddenly stopping could be dangerous, for example the abrupt withdrawal of long term steroids.

i. Handling the medicines and medical devices summary at the receiving end

9.8.2.1 Guidelines for safe on screen display of medication items should be followed in design for display of medication in outpatient letters. The NPSA guidance can be accessed [via the NPSA website.](#)

9.8.2.2 Where the hospital systems use dm+d, those items which are prescribable in primary care will be represented in dm+d. Those which are not prescribable in primary care will need to be recorded as textual items.

9.8.2.3 For display purposes "indicator" should be displayed as "reason for medication" and "reason for medication change" as these are more acceptable terms to patients.

ii. Medicines Reconciliation

9.8.3.1 This section primarily applies to the GP receiving system. Between outpatient appointments and when a patient is discharged from an outpatient service any change in medication generally involves a handover of responsibility for prescribing from outpatient clinician to GP.

9.8.3.2 The outpatient letter should inform the GP of medications that have been changed, discontinued or added as result of the attendance along with reasons for these changes. The responsible GP prescriber will therefore need to review the patient's GP medication record, which is likely still to

represent the medications that were current at the time of attendance, and to reconcile this with medication recommendations in the outpatient letter. It will therefore be helpful to enable the receiving GP prescriber easily to compare the intended list of medications listed in the outpatient letter with the patient's recorded current medication. Any changes that may as a result be made to the patient's current medication should be subject to the usual prescribing decision support / alerts as for any other addition / change / discontinuation of medication that prevails when any change is made to the GP medication record.

9.8.3.3 In the short term this will require reading each individual outpatient medication and then making any appropriate changes to the GP patient medication record manually. In time, as hospital systems become able to transmit dm+d coded medications it may become possible for suppliers to utilise these codes to assist the GP in finding the appropriate medicinal product that needs to be added / changed / discontinued. Longer term, the expectation is that in many cases it will be possible to utilise both the dm+d code and also a structured statement of dosage to compute the most likely equivalent GP prescription and to present this to the GP prescriber.

9.8.3.4 For the avoidance of doubt, changes to the GP medication record resulting from outpatient letters MUST always require the authorisation of the responsible GP prescriber.

iii. Dose based compared with Product based prescribing

9.8.4.1 In UK General Practice systems "product based prescribing" is used, so called because medicinal products are prescribed. An example of this is:

"Furosemide 40 mg tablets, take 2 at 8am".

In contrast Hospital systems often use "dose based prescribing" which is not dependent on using any particular product but starts with a drug name and then links this to a dose amount and a dose frequency. The same example as above but expressed as dose based prescription would be:

"Furosemide 80mg oral at 8 am".

9.8.4.2 It can be seen that in product based prescribing the size of the tablet / capsule / inhalation / etc. is usually explicitly stated as part of the product name and that typically the route of administration is implicit. In contrast, dose based prescribing starts with the drug name and then typically explicitly builds a dose string out of dose amount, route, and dose timing. Both of these prescribing patterns are therefore supported in the Medication item entry of the outpatient letter Medications and medical devices information model.

9.8.4.3 It is recommended that the fields in the Medication item entry should be used as follows.

For Product based prescribing:

- Medication name: Enter the medicinal product (e.g. “Furosemide 40 mg tablets”). In dm+d terms this would be either Actual Medicinal Product (AMP) or Virtual Medicinal Product (VMP)
- Dose directions description: Enter the remaining dose direction (e.g. “take 2 at 8 am”). Information about route may also be included in this same text string but is generally omitted

For Dose based prescribing:

- Medication name: Enter the drug name (e.g. “Furosemide”). In dm+d terms this would be Virtual Therapeutic Moiety (VTM)
- Form: Optional (e.g. “capsules”, “tablets”, “liquid” etc.)
- Route: Optional (e.g. “oral”, “intraocular”, “intramuscular” etc.)
- Dose amount: A plain text description of dose amount (e.g. “80 mg”)
- Dose timing: A plain text description of medication dose frequency (e.g. “once daily”, “at 8 am”)
- Site and method are other optional fields that may be used.

iv. Plans for future structured dose syntax

9.8.5.1 The intended direction of travel is to move towards a future:

- a) where all health care prescribing systems express drug names using dm+d coding both for product based and for dose based prescribing and
- b) where all health care prescribing systems can also generate a parsable dose directions string that will incorporate all of the remaining information beyond the drug name that is essential to express an unambiguous prescription.

9.8.5.2 Through a combination of using dm+d and also parsing of these structured dose strings it should then be possible to convert a dose based prescription to a semantically equivalent product based prescription and vice versa. Depending on the structured dose syntax solution eventually adopted it is anticipated that upwards from 80% of all prescriptions could be automatically converted between dose based and product based expressions of prescriptions. Components are already included in the Medications and medical devices information model to support structured dose syntax and its processing

j. Safety alerts

- 9.9.1 This section is subject to change pending the outcome of a review by the Professional Record Standards Body of the heading “safety alerts” and the data item “safeguarding” (located in the “Legal information” heading).
- 9.9.2 There may be situations where it not advisable to share information in this section with the person to whom it relates or their carer. Appropriate policies and technical solutions need to be in place for these situations to ensure that the information is included in their letter copies.
- 9.9.3 Given the particular importance and sensitive nature of this type of information, this section should not be prepopulated.

k. Allergies and adverse reactions

- 9.10.1 A full record should be provided of:
- a) allergies that the patient tells the outpatient clinic about
 - b) allergic and adverse reactions related to their encounter.
- 9.10.2 If relevant investigations and observations have been carried out and no allergies or adverse reactions identified then this heading should appear in the outpatient letter with the text “**No known drug allergies or adverse reactions**”. If no information is available about allergies or adverse reactions (but allergies or adverse reactions may have been identified), then this heading should appear in the outpatient letter with the text “**Information not available**”.
- 9.10.3 Guidance on good practice recording of allergies and adverse reactions is provided by NICE. This relates to end systems rather than the outpatient letter, but is included here as its use should improve quality of the information communicated by the hospital.

l. Investigation results

- 9.11.1 Only important or relevant results should be included in the outpatient letter, ie those that the clinician wants to communicate to the GP. This is to reduce the risk of overload of information irrelevant to the GP.
- 9.11.2 This can be a difficult decision to make and so consideration should be given to ways that a clinician could be helped in this task.
- 9.11.3 It is important for the hospital clinician to record why they have done the test and where relevant, who is going to follow up (i.e. GP or hospital).

9.11.4 Investigations carried out where results are not yet available should be recorded in this section.

m. Participation in research

9.12.1 When a patient is enrolled on a drug trial/ intervention, the GP receives detailed information from the research sponsor. To avoid duplication the outpatient letter need contain the following information only:

- Drug/intervention name
- Trial name (and URL if possible)
- Whether the patient is currently involved in a trial.

n. History

9.13.1 History relevant to the outpatient attendance is recorded here.

9.13.2 *“Patient’s reason for referral”* SHOULD be communicated in outpatient letters following an initial outpatient appointment. It MAY be communicated in outpatient letters following a follow-up appointment.

9.13.3 *“History of each presenting complaint or issue”* SHOULD be communicated in outpatient letters following an initial outpatient appointment. It MAY be communicated in outpatient letters following a follow-up appointment.

9.13.4 *“Relevant past medical, surgical and mental health history”* SHOULD be communicated in outpatient letters following an initial outpatient appointment. It MAY be communicated in outpatient letters following a follow-up appointment.

SNOMED CT coding of past history as offered by the patient may have little to offer, especially when trying to capture the nuances of history as related by the patient. For example, the patient knows that they had an operation on their stomach but can’t remember the details.

o. Information and advice given

9.14.1 In some instances outpatient healthcare professionals may want to communicate to the GP specific information and advice which was given to the patient. It is important that this is concise and is only information which it is pertinent for the GP to be aware of.

9.14.2 Where patients are provided with literature (e.g. pamphlets) there is no need to provide details of the information contained in the literature e.g simply state that the patient was provided with a pamphlet.

9.14.3 The default is that patients (or their designated carer or guardian where applicable) should get a copy of the outpatient letter. Where this is not possible an explanation should be provided in the clinical summary.

p. Plan and requested actions

9.15.1 The plan should make clear who is expected to take responsibility for actions following the encounter, eg the person receiving care or their carer; the GP or another health care professional. For example, follow up renal function test to be arranged by the GP within two weeks of appointment.

9.15.2 Scheduled follow-up appointments at the outpatient clinic and transfer of care back to the GP are NOT included here. They are included in the “Attendance details” heading.

9.15.3 Shared decision making principles should apply to the development of the plan and where the patient’s opinions differ, this should be recorded under the heading “clinical summary”.

9.15.4 Care programme approach (CPA) status: Whether the patient is subject to STANDARD CARE or CPA. (Care Coordination Association)

q. Legal information

9.16.1 Systems should allow copies of legal documentation to be attached to the record where it would be necessary to see copies of the original documents (e.g. mental health act status, ‘lasting power of attorney for personal welfare’).

9.16.1 “*Consent to sharing information*”: Local consideration needs to be given to how an author of an outpatient letter will ensure that the patient has given consent for individual data items to be included, when that information has been recorded by different health care professionals. For example, when a nurse authors an outpatient letter that includes items from physiotherapy or occupational therapy.

9.16.2 “*Mental capacity assessment*”

- Mental capacity needs to be assessed at each moment where treatment decisions need to be made.
 - Mental Capacity Act 2005 (England and Wales)
 - Adults with Incapacity Act 2000 (Scotland)
 - Mental Capacity Act 2016 (Northern Ireland).

- If there is a need to communicate the outcome of a mental capacity assessment it is important to record to which specific decision it relates.

9.16.3 “*The Mental Health Act (MHA) status or equivalent*”: This data item SHOULD include:

- Information pertaining to the MHA status of the patient.

9.16.4 “*Safeguarding issues*”: Record which agencies (i.e. social services, police, voluntary sector) have been sent relevant documentation with their contact details and dates e.g. adult safeguarding. Please note that this data item and accompanying guidance may change depending on the outcome of a review by the Professional Record Standards Body.

r. Distribution list

9.17.1 The overall heading ‘Distribution list’ is OPTIONAL, which means that it is a local decision as to whether some or all of those to whom the letter is distributed is communicated in the letter. However, should the person completing the letter decide to communicate a list of all or some of the persons to whom the letter is sent then the ‘MANDATORY’ elements MUST be completed for each person listed, and the ‘REQUIRED’ elements SHOULD be completed for each person listed.

10 Appendices

a. Exemplar letters

Available on the PRSB website at: <http://theprsb.org/publications/outpatient-letter-standards>

b. Deviations from 2013 PRSB/Academy outpatient headings

Since the PRSB/Academy headings were published in 2013, there has been feedback suggesting changes to some of the headings. Consultation has been undertaken and the following headings have been changed. Where the original headings have already been implemented, implementers will need to consider updating their local information models. To inform this, the original and the new heading or change are set out on the table below:

	2013 Heading	Change made	Reason
1.	Patient demographics	Patient sex removed	Not relevant for outpatient letter to GP.
2.	Patient demographics	Ethnicity removed	Not relevant for outpatient letter to GP.

	2013 Heading	Change made	Reason
3.	Patient demographics	Communication preferences removed	Covered by individual requirements.
4.	Patient demographics	Education establishment added	Relevant for those who provide healthcare for children.
5.	Special requirements	Individual requirements	Feedback from patients and carers.
6.	Participation in research	Participation in research element replaced with Name of research study	To reflect change in description. Data items covered by 'Participation in research' sent to GP separately by research study.
7.	Outpatient details	Changed to Attendance details	To align with hospital discharge summary heading.
8.	Outpatient details	Purpose of contact removed	Not relevant for outpatient letter to GP.
9.	Outpatient details	Patient location removed	Not relevant for outpatient letter to GP.
10.	Outpatient details	Appointment time removed	Not relevant for outpatient letter to GP.
11.	Outpatient details	Time patient seen removed	Not relevant for outpatient letter to GP.
12.	Outpatient details	Time consultation finished removed	Not relevant for outpatient letter to GP.
13.	Outpatient details	Date of appointment/contact added	To communicate date of appointment/contact.
14.	Outpatient details	Outcome of patient attendance added	To capture discharge or details regarding follow-up appointment.
15.	Referral details	Referrer details	Referrer is more appropriate as the section only contains information about the referrer.
16.	Referral details	Referral to, Referral method and Urgency of referral removed	Onward referrals covered in Plan and requested actions, in line with hospital discharge summary.

	2013 Heading	Change made	Reason
17.	History	Reason for referral removed	Not relevant for outpatient letter to GP.
18.	History	Information brought by patient removed	Not needed as separate heading.
19.	Safety alerts	Risk from others added	To record where a person is at risk from someone else.
20.	Medications and medical devices	The terms Reason for medication and Reason for medication change have been changed to Indication.	For consistency with the SCIMP (Scottish clinical information management in practice) medications information model.
21.	Medications and medical devices	Placeholders for structured dose syntax have been added to the model.	Further work is required to develop structured dose syntax. Placeholders used for the two modelling options.
22.	Allergies and adverse reaction	Changed to allergies and adverse reactions	May be multiple adverse reactions recorded.
23.	Allergies and adverse reaction	Type of reaction added as separate element (in 2013 it is located under Description of reaction)	Align with hospital discharge summary.
24.	Allergies and adverse reaction	Severity added as separate element (in 2013 it is located under Description of reaction)	Align with hospital discharge summary.
25.	Allergies and adverse reaction	Certainty added as separate element (in 2013 it is located under Description of reaction)	Align with hospital discharge summary.
26.	Legal information	Consent for treatment record removed	Not relevant for outpatient letter to GP.

	2013 Heading	Change made	Reason
27.	Legal information	Advance decisions about treatment has been changed to advance decisions to refuse treatment (ADRT) and a separate heading, 'advance decisions' has been moved to patient and carer concerns expectations and wishes section. ADRT description has been updated.	ADRT are legally binding, but advance decisions are not.
28.	Legal information	Lasting or enduring power of attorney or similar has been changed to lasting power of attorney for personal welfare or equivalent. Description has been updated.	Heading and description made more specific.
29.	Legal information	Deprivation of Liberty Safeguards (DoLS) or equivalent added	To record DoL and reason for this. Aligned with ambulance transfer of care to ED headings and mental health hospital discharge summary.
30.	Legal information	Organ and tissue donation removed	Not relevant for outpatient letter to GP.
31.	Legal information	Mental Health Act (MHA) or equivalent added	To record information related to MHA. Aligned with mental health discharge summary.
32.	Social context	'Lives alone removed' added	Covered by household composition heading.
33.	Social context	Educational history added	Relevant to children and young people.
34.	Social context	Drug/substance abuse added	To align element with mental health discharge summary. Definition examines current and not former abuse.
35.	Social context	'Lifestyle' reference to drug use removed from definition	This info belongs in new drug element.

	2013 Heading	Change made	Reason
36.	Patient and carer concerns	Changed to patient and carer concerns expectations and wishes	Section heading and label given to the content should be the same.
37.	Patient and carer concerns	Advance statement element added	To capture information related to advance statements
38.	Clinical summary	Investigation results moved into its own section	Records of investigations and results should be separated from a textual clinical summary.
39.	Examination findings	Two elements created called (1) Examination (2) Examination finding To replace PRSB/Academy list of 13 named examination findings, eg vital signs, head and neck examination.	To simplify.
40.	Diagnoses	Differential diagnosis removed and Stage and comment added	To align with work undertaken with hospital discharge summary diagnoses information model
41.	Investigations and results	Changed to Investigation results	To reflect change in description.
52.	Investigations and results	Procedures requested removed	This is included under plan and requested actions.
53.	Information given	Information and advice given	Section heading and label given to the content should be the same.

	2013 Heading	Change made	Reason
54.	Plan and requested actions	Care planning arrangements added.	Added to electronic hospital mental health discharge summary and included in Outpatient letter.
55.	Plan and requested actions	Actions replaced by (1) Actions for patients and carers and (2) Actions for health care professionals	To aid GPs and other healthcare professionals to immediately identify actions for them.
56.	Plan and requested actions	Next appointment details removed	This is included under Attendance details